MISSOURI STATEWIDE HEALTH REFORM DEMONSTRATION

FACT SHEET

Name of Section 1115 Demonstration:	Missouri Managed Care Plus (MC+)
Date Proposal Submitted:	June 30, 1994
Date Proposal Approved:	April 29, 1998
Implemented:	September 1, 1998

SUMMARY

The approved demonstration is a statewide program that provides Medicaid managed care to all eligible adults and children in the state with gross income up to 300% FPL. The demonstration runs concurrently with the State's current Section 1915(b) waiver, also known as Managed Care Plus (MC+). Enrollment of children into the program began August 1, 1998, with services starting September 1, 1998. Enrollment of adults into the program began January 1, 1999, with services starting February 1, 1999. As of February 1, 1999, the demonstration was fully implemented.

ELIGIBILITY

The demonstration extends coverage to the following populations:

- Children up to age 19 with incomes up to 300 percent of the FPL (Missouri receives the enhanced match rate under title XXI for this population.)
- Working parents who are transitioning off of welfare (TANF) and who have a Medicaid eligible child in the home, up to 300% FPL, for a maximum of two-years
- Uninsured custodial parents with incomes up to 100% FPL
- Uninsured non-custodial parents who are participating in Missouri's Parent's Fair Share program with incomes up to 100% FPL
- Uninsured non-custodial parents with incomes up to 125% FPL who are actively paying their legally obligated amount of child support, for a maximum of two years
- Uninsured women losing their Medicaid eligibility for 60 days post-partum, regardless of income, for a maximum of two years

With the exception of parents transitioning off welfare and post-partum women, applicants who have dropped private coverage within six months of applying are not eligible.

BENEFIT PACKAGE

The following populations receive a commercially oriented benefit package that is based on coverage offered to State employees:

- Working parents transitioning off welfare, up to 300% FPL
- Uninsured custodial parents with incomes up to 100% FPL
- Uninsured non-custodial parents with incomes up to 125% FPL who are actively paying their legally obligated amount of child support

Eligible children receive all Medicaid benefits, except non-emergent medical transportation.

Eligible non-custodial parents participating in the Parent's Fair Share program received a commercially oriented benefit package based on employee coverage, with the addition of non-emergent medical transportation.

Eligible post-partum women receive women's health services only. This includes: contraception counseling, devices, pharmaceuticals, and implants; pap smears and pelvic exams; and sexually transmitted disease testing and treatment. These benefits are available through fee for service.

ENROLLMENT/DISENROLLMENT PROCESS

Program applications are typically submitted through a mail-in process. Eligibility is primarily determined in service centers with telephone help lines. Applications may also be submitted in local offices.

The State uses an enrollment broker, as under the current 1915(b) MC+ waiver, to help beneficiaries choose a plan, and beneficiaries who do not choose a health plan are autoassigned. Once beneficiaries enroll in a health plan, they are locked-in for 12 months. During the first 90 days, beneficiaries can change health plans without cause, and beneficiaries may change health plans at any time during the year for good cause as determined by the State. They are notified at least 60 days before each enrollment of their option to change plans.

Adults and children can be disenrolled for failure to pay the premiums or for a pattern of failure to pay the co-payments. Prior to disenrollment, the State will determine whether any extenuating hardship circumstances were present. Beneficiaries who are disenrolled may reapply after six months.

DELIVERY SYSTEM

Post-partum women eligible under the demonstration receive services under the fee-for-service system. All other eligible populations receive services through managed care where the 1915(b) MC+ waiver has been implemented, with the exception of certain individuals not required to enroll in managed care under the 1915(b) MC+ waiver. In the regions of the state in which managed care has not been implemented, services are provided through the fee-for-service system.

QUALITY ASSURANCE

The State uses HEDIS and HEDIS-like measures to monitor quality. The State also monitors the autoassignment rate, new enrollment by region, provider and recipient comments and concerns.

In addition to other analytical tools and reports, Missouri uses a program similar to Geo Access to monitor access. The State conducts annual health plan reviews and also has a contract with an independent professional review organization (PRO) or a PRO-like entity to perform an annual external review.

COST-SHARING

The following populations are required to pay $10 per office visit and $5 per prescription:

- Working parents transitioning off welfare, up to 300% FPL
- Uninsured custodial parents with incomes up to 100% FPL
- Uninsured non-custodial parents with incomes up to 125% FPL who are actively paying their legally obligated amount of child support

Eligible post-partum women and uninsured non-custodial parents participating in the Parent's Fair Share program are not subject to cost sharing charges.

Eligible children are subject to the following cost sharing scale.

- Children with family incomes up to 185% FPL are not subject to cost sharing.
- Children with family incomes from 186% - 225% FPL are subject to co-payments equal to the average co-payment of the Missouri Consolidated Health Care Plan.
- Children with family incomes from 226% - 300% FPL are subject to co-payments and monthly premiums equal to the average co-payment of the Missouri Consolidated Health Care Plan. This premium currently ranges from $83 and $218 per month.

Because these children are part of the state Children's Health Insurance Program (SCHIP) under title XXI, all SCHIP cost-sharing requirements must be met. No family will pay more than the five percent of their income for cost sharing. Each family's cost sharing limit is calculated at the time of eligibility determination. Families are asked to track their cost sharing expenses and notify the State when they reach their limit. Cost sharing requirements will be suspended for the remainder of the twelve-month eligibility period for families who reach their individual limit.

A pattern of failure to pay the co-payment or failure to pay the premium could result in disenrollment.

MODIFICATIONS

CMS approved a modification on January 11, 1999, which allows the State to impose cost sharing on children and disenroll beneficiaries who show a pattern (four or more instances) of failing to pay the co-payment requirements. Providers may not deny services based upon a lack of co-payment, but must keep a record of such instances and report them to the State. The State will evaluate the effects of not providing non-emergency medical transportation and on the

effects of imposing cost sharing on children, including the disenrollment provisions.

CMS approved a modification on February 3, 1999, to allow the State to expand eligibility to uninsured non-custodial adults with incomes up to 125% FPL. Prior to this modification, these adults were covered up to 100% FPL. This eligibility expansion was mandated by the State legislature.

A modification was approved on June 28, 1999, to increase monthly premiums from $65 to $68 for children with incomes between 226% and 300% FPL. This increase was mandated by the State legislature in accordance with changes to the Missouri Consolidated Health Care Plan.

A modification was approved on January 19, 2001, to allow the State to increase monthly premiums from $68 to $80 for children with incomes between 226% and 300% FPL. A clarification of this approval was provided on January 23, 2001, to allow the State to increase the pharmacy co-payment from $5 to $9 for this same group. This increase was mandated by the State legislature in accordance with changes to the Missouri Consolidated Health Care Plan.

A modification was approved on May 30, 2001, to allow the state to increase monthly premiums modify their premium from $80 to between $83 and $218 for children in families with incomes between 226% and 300% FPL. The exact amount of the premium will be determined by a sliding scale methodology outlined by the state in its letter requesting the amendment. This increase was mandated by the state legislature and was necessary to allow 3,500 children to continue to receive health care. All other requirements of the waiver will remain in effect.

CMS approved a modification on August 1, 2002, entitled “Health Care for the Indigent of St. Louis.” This amendment has two purposes: to transition ConnectCare, a public-private hospital in St. Louis, from an inpatient to an outpatient facility, and to enable the St. Louis region to transition its “safety net” system of care for the medically indigent to a viable, self-sustaining model. To achieve this, CMS approved expenditure authority for state-funded expenditures incurred by the St. Louis Regional Disproportionate Share Hospital (DSH) Funding Authority between June 28, 2002, and February 29, 2004. This authority expires prior to March 1, 2004, which is the expiration date of authorities granted in the April 28, 1999, MC+ approval letter.

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9/19/02